Navigating Prior Authorization: A Provider's Guide to Success: Prior Authorization

2025 IHCP Works Annual Seminar

Presented by Kristy Huse, Provider Account Manager (Medical)

Optum Behavioral Health: Paulette Means and Kristin Johnson

UnitedHealthcare Vision: Elizabeth Faceson

UnitedHealthcare Dental: Kelly Davis

United Healthcare

Agenda

1. Admission Notification
2. Obtaining Prior Authorization for Medical:
   - Requirements
   - Chat Support
   - Education and Training
   - Point of Care Assist
3. Behavioral Health
4. Dental
5. Vision

Our Service Lines

- UnitedHealthcare

- Optum® Behavioral Health

- March® Vision Care

- UnitedHealthcare Dental

Admission Notification

Admission Notification

Admission notification: General acute care facilities should notify UHC of the inpatient admission within 48 hours after admission. Nursing facilities should follow notification and Level of Care requirements for admission as outlined in the IHCP Long-Term Care Provider Reference Module

Notify UnitedHealthcare of an Admission:

- Electronic Data Interchange (EDI) 278N Transaction (easiest and most preferred method)
- Online via the Prior Authorization and Admission Notification (PAAN) tool:UnitedHealthcare Provider Portal resources | UHCprovider.com
- Via phone at 877-610-9785 8 a.m. – 8 p.m. ET Monday – Friday
- Via Fax at 844-897-6514: Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana | UHCprovider.com

Note: Non-member specific information is available without logging in, this includes Crosswalks, Administration Guides, Peer to Peer Request, Etc.
Member specific information is available after log into UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com

Admission Notification – EDI 278N Transaction

- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UHC in a standard format

- It can be transmitted directly to UnitedHealthcare or through a clearinghouse in either batch or real-time format

- To get started, contact your vendor or clearinghouse. Most clearinghouses already send 278N transactions to UnitedHealthcare and can work with you to submit notifications in the appropriate format

- For additional information regarding the EDI 278N Transaction please visit our website at:

  EDI 278N: Hospital Admission Notification | UHCprovider.com

Prior Authorization Requirements for Indiana Hoosier Care Connect & Indiana PathWays for Aging

Prior authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part for our managed care organization.

Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent, and retrospective care review.

*Prior authorization is ***not required*** for emergency or urgent care

Medical

Medical: Check Prior Authorization Requirements

Providers can check prior authorization requirements at:

[UnitedHealthcare Community Plan of Indiana Homepage]

Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana Hoosier Care Connect]
[Prior authorization requirements for Indiana Pathways for Aging]

Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Last update: May 29, 2025

We have online tools and resources to help you manage your practice's notification and prior authorization requests.

To submit and manage your prior authorizations, please sign in to the UnitedHealthcare Provider Portal. Additional information on prior authorizations is available on **uhcprovider.com/priorauth**.

Sign in

Current Prior Authorization Plan Requirements

- **UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2025**
- **UnitedHealthcare Community Plan Prior Authorization Indiana PathWays for Aging - Effective July 1, 2025**

Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana Pathways for Aging effective Aug. 1, 2025]

Note: Use Ctrl-F to search for a specific CPT or HCPCS code:

General information

This list contains prior authorization requirements for participating UnitedHealthcare Community Plan of Indiana health care professionals providing inpatient and outpatient services. Please submit your request in 1 of the following ways:

- **Online:** Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. To get started, go to **UHCprovider.com** and click Sign In in the top-right corner to log in using your One Healthcare ID and password. Then, select the Prior Authorization and Notification tab on your dashboard. If you don't have a One Healthcare ID, visit **UHCprovider.com/access**.
- **Phone:** Call **877-610-9785**

Prior authorization is not required for emergency or urgent care. Out-of-network requests must be made by network care provider.

Procedures and services	Additional information	CPT® or HCPCS codes and how to obtain prior authorization			
Bariatric	Prior authorization is required. There is a Center of Excellence requirement for coverage of bariatric surgery and services. In certain situations, bariatric surgery and other obesity-related services aren't covered by some benefit plans.	43644 43771 43775 43846 44705	43645 43772 43842 43847	43659 43773 43843 43848	43770 43774 43845 44799

Medical: Check Prior Authorization Requirements (Provider Portal)

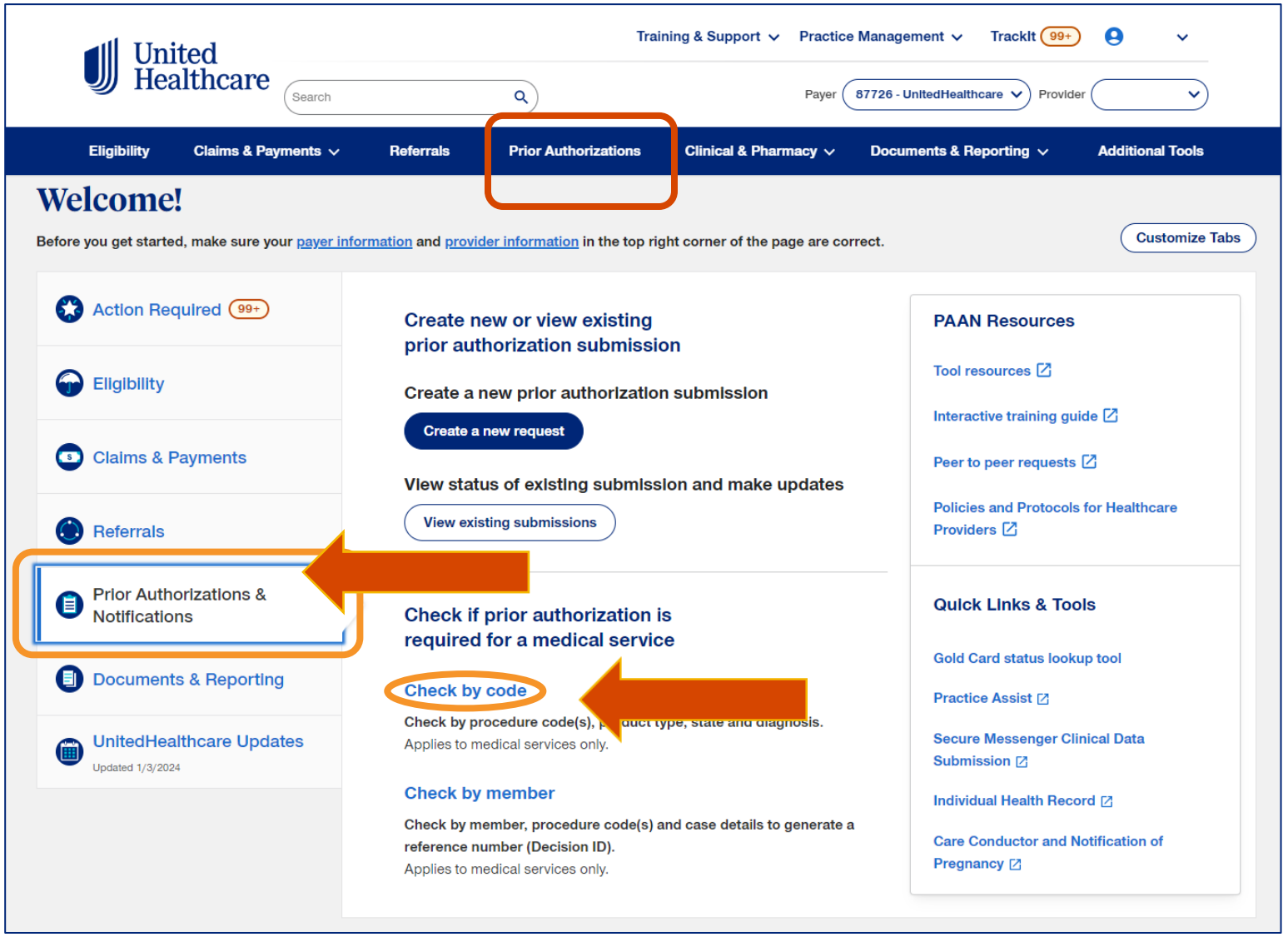
Use the Prior Authorization and Notification tool via our UnitedHealthcare Provider Portal to:

UnitedHealthcare Provider Portal resources | UHCprovider.com

- Determine if notification or prior authorization is required
- Complete the notification or prior authorization process
- Upload medical notes or attachments
- Check request status and advance notification/lists

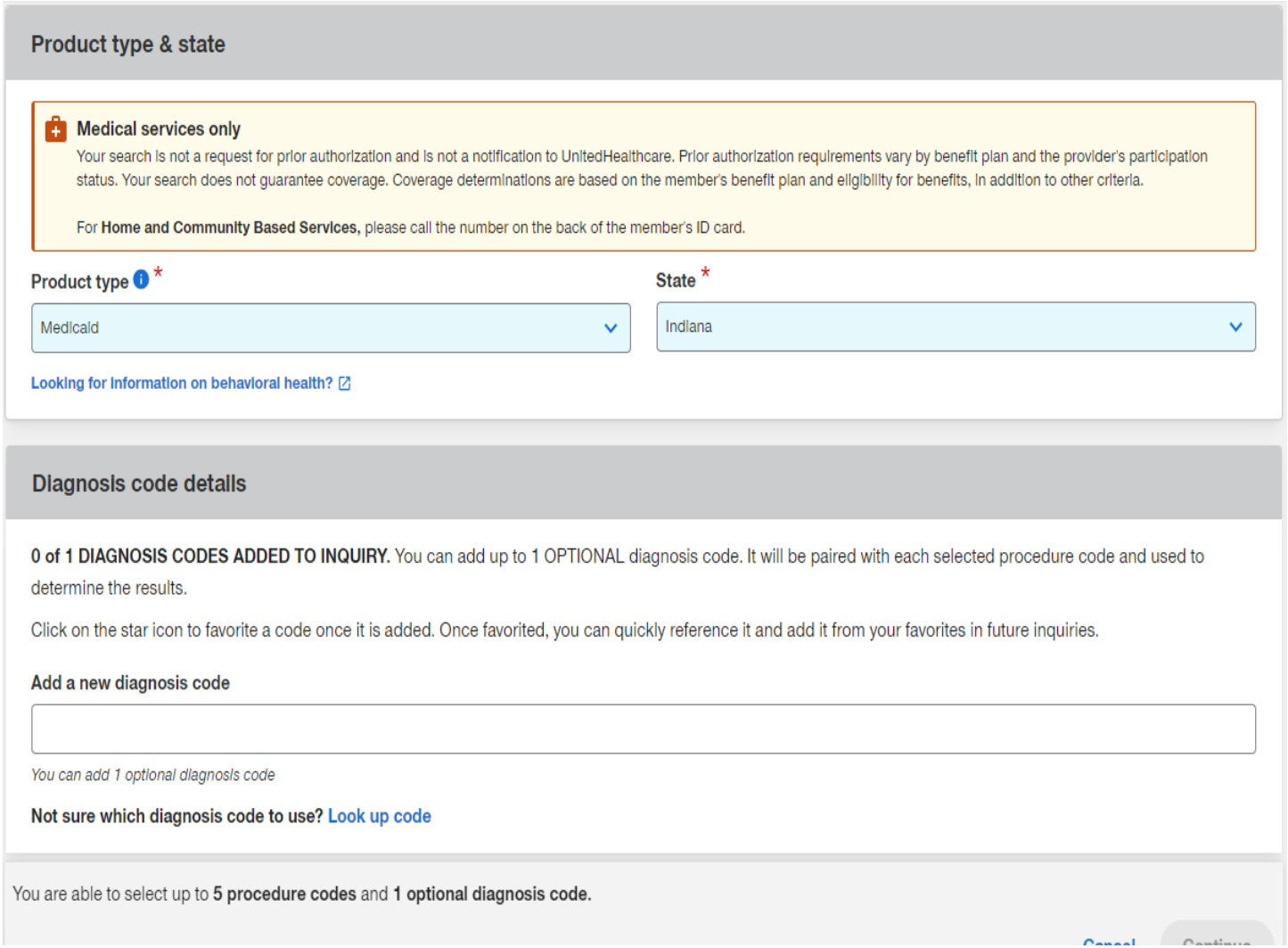
Medical: Check Prior Authorization Requirements (Portal Sign in)

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Check by code”



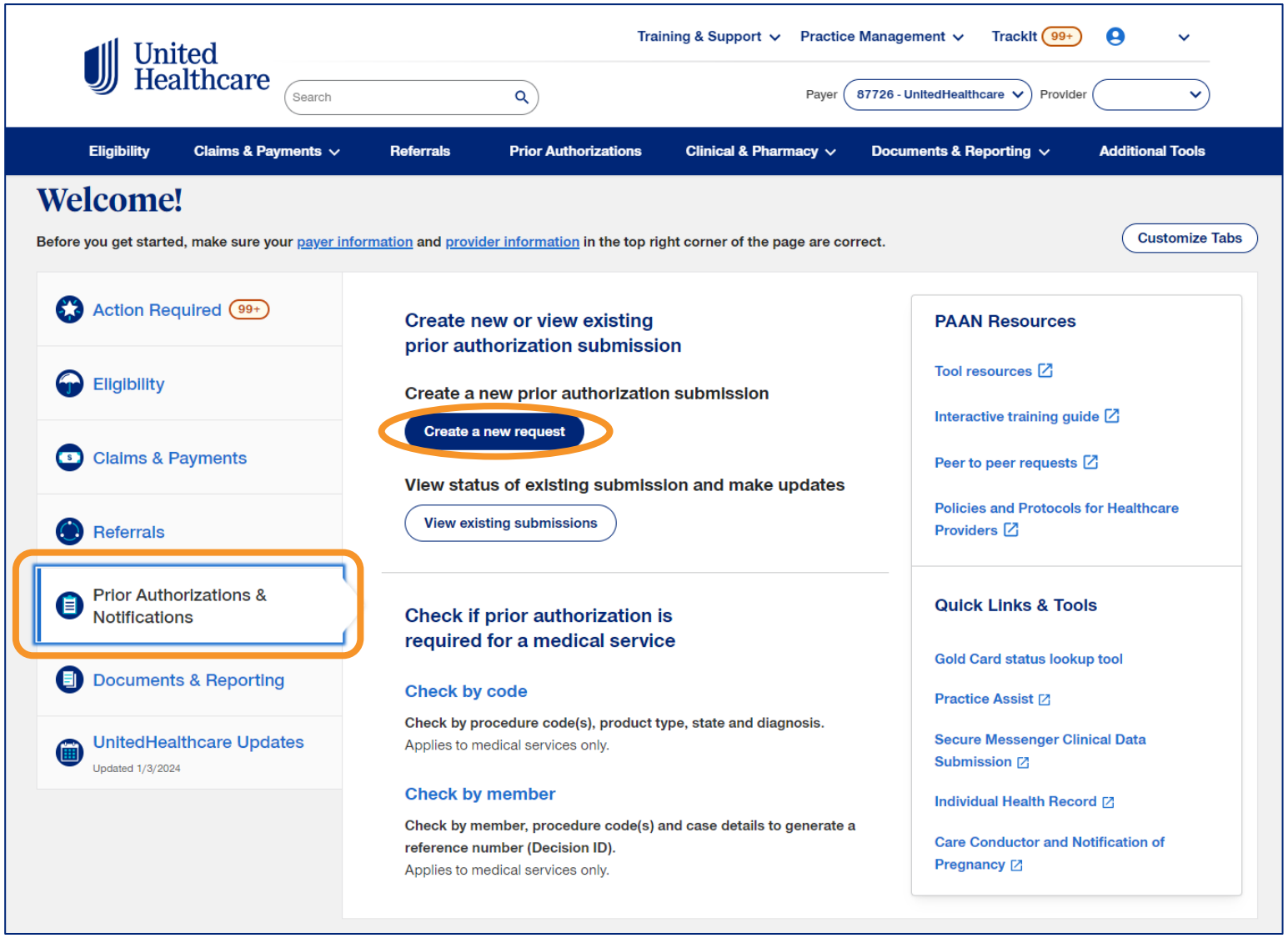
Medical: Check Prior Authorization Requirements (Portal entries)

1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)



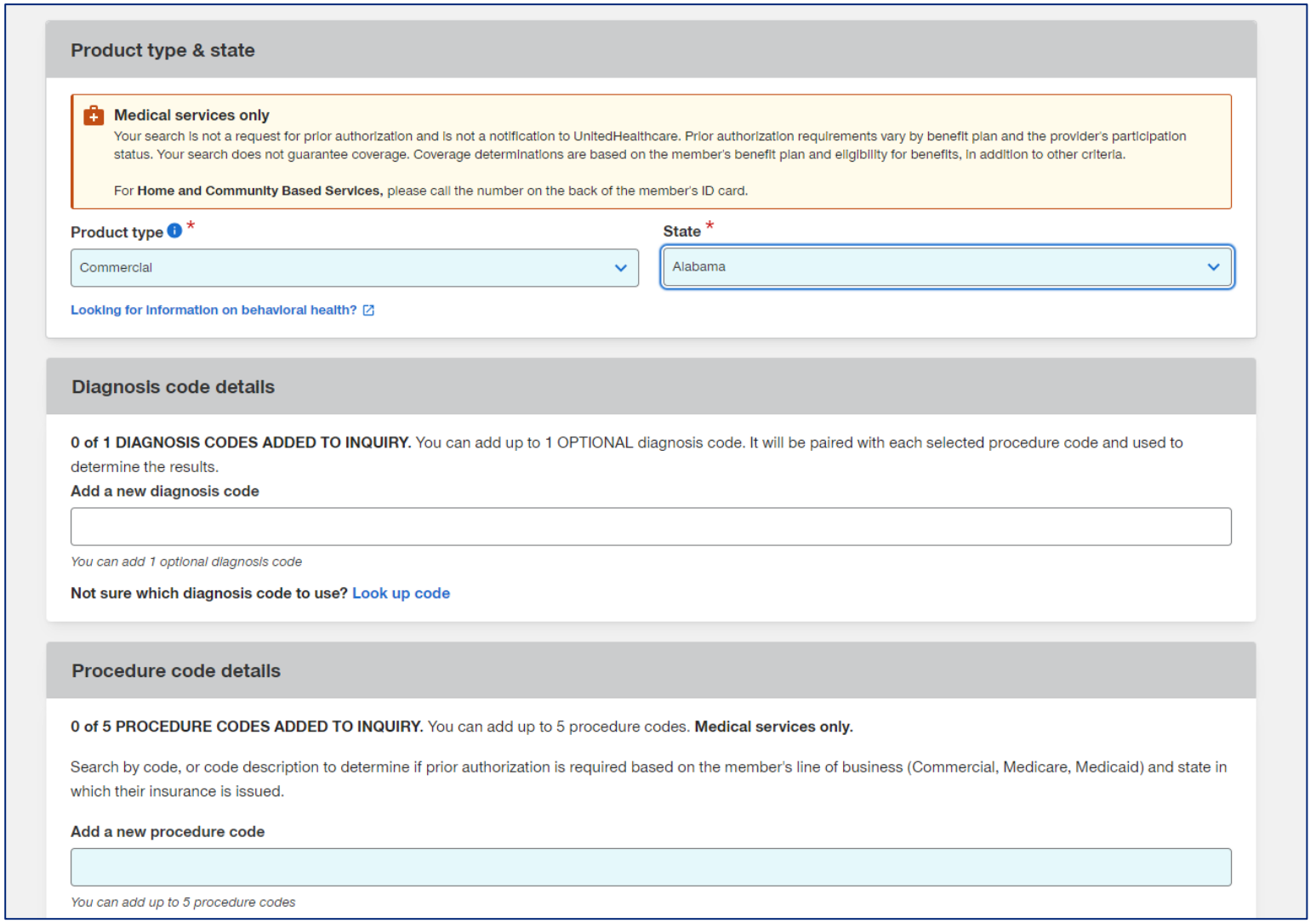
Medical: Create New Prior Authorization

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Create a new request”



Medical: Creating a New Prior Authorization (entries)

1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)



Medical: Prior Authorization Submission Tips

- If the rendering provider you are trying to select is not an option, select another provider within the group for the authorization
- Use the “Find Facility” search tool to locate the facility where the service will be performed
- Use the asterisk symbol (*) to help you find the results you are looking for. Typing less with a wildcard will help return the results you are looking for
- UnitedHealthcare Community Plan uses InterQual® for medical care determinations
- You can access our UnitedHealthcare Community Plan of Indiana Clinical Guidelines: Clinical Practice Guidelines (National) - UnitedHealthcare Community Plan

Medical: Tips to Avoid Prior Authorization Denials

- Be thorough and complete all the requested documentation
- Ensure that you are answering all authorization questions
- All prior authorizations must have the following:
  - Patient name and Medical ID number
  - Ordering care provider or health care professional name and TIN/NPI
  - Rendering care provider or health care professional and TIN/NPI
  - ICD-10 Diagnosis Codes
  - Anticipated date(s) of service
  - Primary and secondary procedure code(s) and number of units or visits, etc., when applicable
  - Service setting
  - Facility name and TIN/NPI, when applicable

Medical: Prior Authorization Requests Must Be Timely

- Problem: UHC does not receive ***routine*** prior authorization requests for scheduled services well in advance of the service date.

- Solution: Submit your prior authorization request online, via the PAAN tool on the Provider Portal as soon as the service/procedure is scheduled.

- For example, if a surgery is scheduled 2 months in advance, submit the prior authorization as soon as possible after scheduling. This will result in a timely determination well in advance of the scheduled service date.

- UnitedHealthcare generally requires a decision on a non-urgent prior authorization request within 7 to 15 days (and up to 14 calendar days), while an urgent request is decided within 72 hours of receiving the request. These timelines are for pre-service requests and are outlined in the provider manual

Medical: Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

- Problem: UHC often does not receive complete clinical information with the authorization request to make a medical necessity determination

- Solution: Following the suggestions below will result in less adverse determinations, more timely decision turnaround times, a reduction in the need for peer-to-peer reviews, and/or requests for additional clinical information:
    - Submitting prior authorizations online via the PAAN tool
    - Submission of all required clinical information
    - Completion of all fields within the online request leaving no fields blank and avoiding answering with “N/A”

Medical: How to Appeal an Adverse Decision

- If a provider's Prior Authorization request is denied, they may request a peer-to-peer review by calling 1-800-955-7615 from 9 a.m.– 6 p.m. ET, Monday–Friday

- If provider disagrees with the peer-to-peer decision, they may file an appeal. Once an appeal is filed a provider cannot go back and request a peer-to-peer review. Please note that even if a peer-to-peer review is not completed, a provider may still file an appeal. All steps in the process are outlined in the decision letter sent by the authorization team

- If it is taking longer than the state mandated turnaround time to receive a decision, escalate to the Provider Account Management team by going to (UnitedHealthcare Community Plan of Indiana Homepage "Contact Us" and reviewing Medical Provider Advocates by Counties Served (For Medical Providers)

Medical: Peer-to-Peer Process

- Peer-to-peer reviews can be requested 7 (HCC), or 15 (PathWays) business days from verbal notification of an adverse determination (this includes Inpatient Level of Care denials)
- A peer-to-peer review should be requested by facilities when Inpatient Level of Care is denied
- A peer-to-peer review can also be requested if a prior authorization for a scheduled procedure is denied
- A prior authorization request that does not meet coverage criteria or lacks sufficient information upon submission may “pend” for a peer-to-peer review

Medical: Prior Authorization Decision Turnaround Times

UnitedHealthcare Community Plan of Indiana Care Provider Manual - Indiana PathWays for Aging Provider Manual (uhcprovider.com)

Type of request	Decision Turnaround Times	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 5 business days or 7 calendar days (whichever comes first) of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request (HCBS notification within 24 hours)
Concurrent review	Within 48 hours	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination; at least 10 business days before the date of action

Medical: Clinical Policies – Example

Over the next few slides, we are going to review clinical policies and will be using Bariatric Surgery as the example, clinical policies will apply to all medical services.

Indiana Medicaid Bariatric Surgery Medical Policy

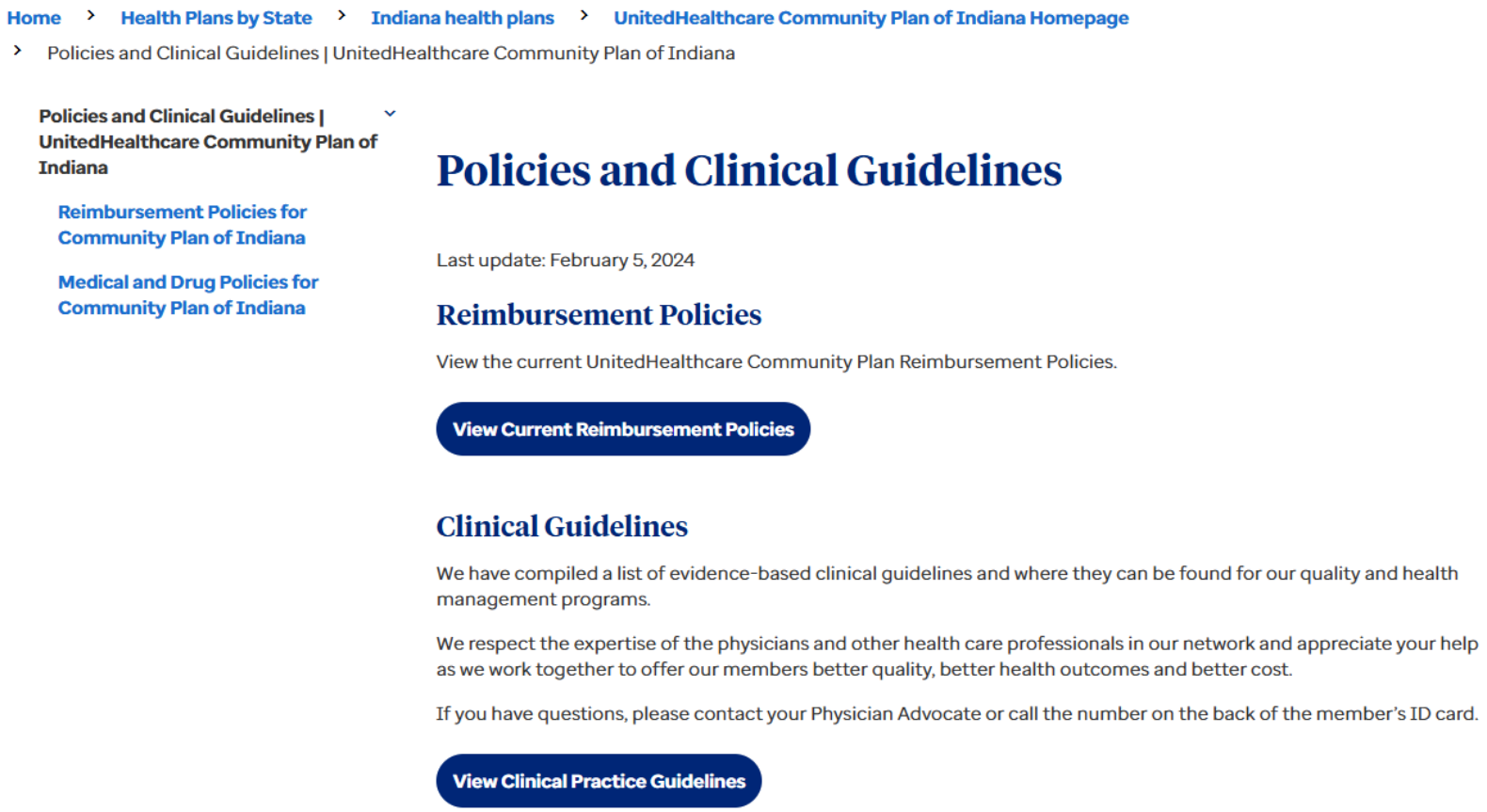
Surgical Services Provider Reference Module

Bariatric Surgery and Revisions

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed.

Medical: Be Familiar with Our Clinical Policies

Providers can view our clinical policies here



Medical: Be Familiar with Other Clinical Policies Cont.

Bariatric surgery

- UHC follows in this order:
  - State and federal medical policy regulations
  - UnitedHealthcare medical policy
  - InterQual medical policy

Medical: Clinical Policies

UHC Medicaid Bariatric Surgery Medical Policy

[Bariatric Surgery – Community Plan Medical Policy]

United Healthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery

Policy Number: CS007.W
Effective Date: April 1, 2025

Instructions for Use

Table of Contents **Page**

Related Community Plan Policies

- Minimally Invasive Procedures for Gastric and Esophageal Diseases
- Obstructive and Central Sleep Apnea Treatment
- Robotic-Assisted Surgery Policy, Professional

Commercial Policy

- Bariatric Surgery

Medical: Process to Dispute a Prior Authorization Decision and File Appeal

When there is an initial adverse determination of a prior authorization request:

- Provider's next available step is a peer-to-peer review
- If the denial is upheld, the provider can then appeal the determination
- If no peer-to-peer was requested and an appeal was filed, then the provider is no longer eligible for a peer-to-peer review
- Provider will receive a letter of adverse determination; it will detail steps needed to request a peer-to-peer review and/or an appeal

Medical: External Review

- When requested, an external review of a prior authorization can be performed by an independent reviewer organization (IRO)
- Member must file the external review request within 120 calendar days from receiving the appeal decision
- We utilize the state's recommended list of IROs to conduct the external review
- A decision by the IRO is made within 72 hours if expedited, or within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare

Medical: State Fair Hearings

- The Indiana Family Social Services Administration maintains a fair hearing process which allows members the opportunity to appeal the contractor's decisions. Members can find out how to submit a request for a state fair hearing here
- Members must first exhaust all grievance and appeal options with UnitedHealthcare
- Members may file for a state fair hearing within 120 calendar days from the adverse determination notice of the final appeal
- The member and member's representative as well as a representative of UnitedHealthcare attends the hearing
- If the member is dissatisfied with the outcome of the hearing, they may request an agency review within 10 days of the administrative law judge's decision

Medical: Retroactive Authorizations and Medical Claim Review

- Retroactive authorization:
  - Retroactive authorizations will be issued when the “No authorization” denial was due to eligibility issues
- Medical claim review (MCR) performs medical necessity reviews on denied claims when a prior authorization/admission notification was not obtained or if inpatient level of care was denied during the member’s inpatient stay
  - Example: Provider obtains authorization for a particular code, then upon entering the surgical site, the provider must perform an additional or different service than what was originally approved
  - The claim would be filed, denied, and then reviewed by the medical claim review team upon submission of a Claim Reconsideration with documentation that supports medical necessity attached
  - MCR would only be used in scenarios in which PA could not be obtained due to retro-eligibility

Chat Support

United Healthcare

Notification/prior authorization case: A226

Flag case

View and update — Verify — Confirm

Collapse all

A decision has already been rendered on this case, though some updates are permitted as indicated in the enabled fields below. To request an additional service for this member, please submit a new notification/prior authorization request for the member.

Case details

Notification/prior authorization number	Case status	Case status reason	Primary care physician
A226	**Closed**	**Case was managed and is now complete**	**—**

Advance notify date/time

01/24/2024, 2:14 PM CST

Coverage status

Test code	Test code review type	Overall coverage status	Decision date
94372	**Unproven**	**Not Covered/Not Approved**	**01/29/2024**

Procedure code associated with the test

Notification/prior authorization case: A226

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94372	**Unproven**	**Not Covered/Not Approved**	**01/29/2024**

Procedure code associated with the test

Back to top

Cancel | Request case cancellation

Message us

Today

HI, I'm your United Healthcare virtual assistant.

To get started please select the topic you need help with.

Claims | Benefits & Eligibility | Prior Authorization | Portal Tech Support | Provider Onboarding

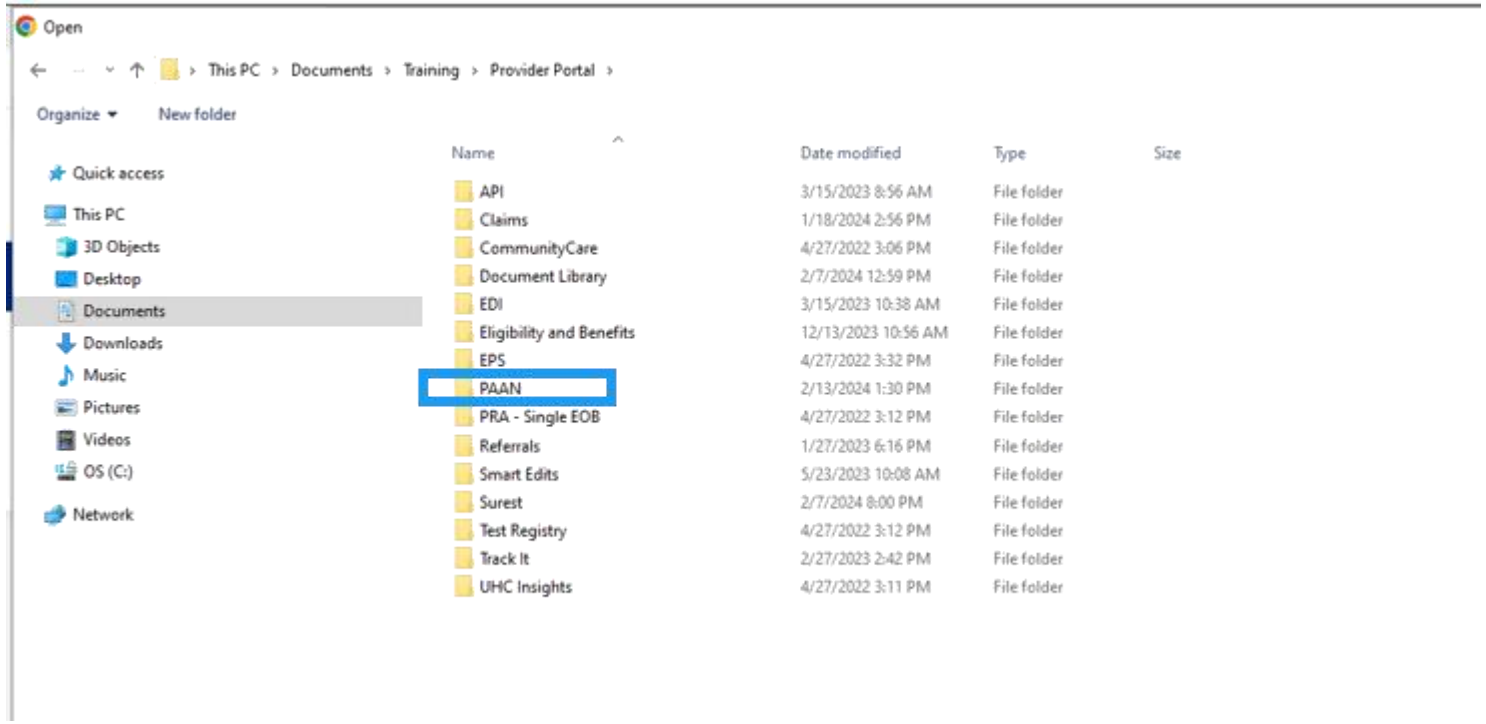
A

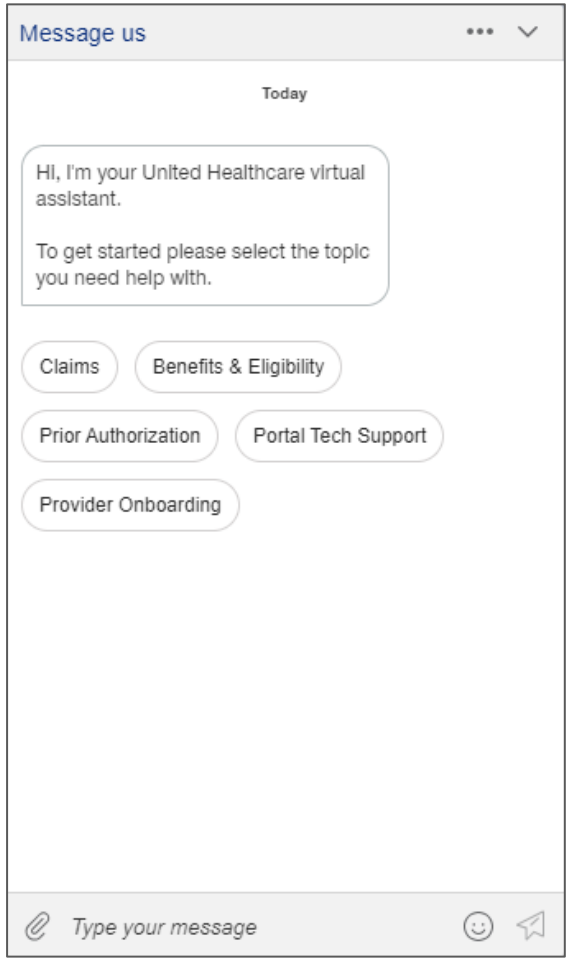
B

Type your message

Feedback

Attach a Document





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Education and Training

Resources for the Provider Portal

United Healthcare

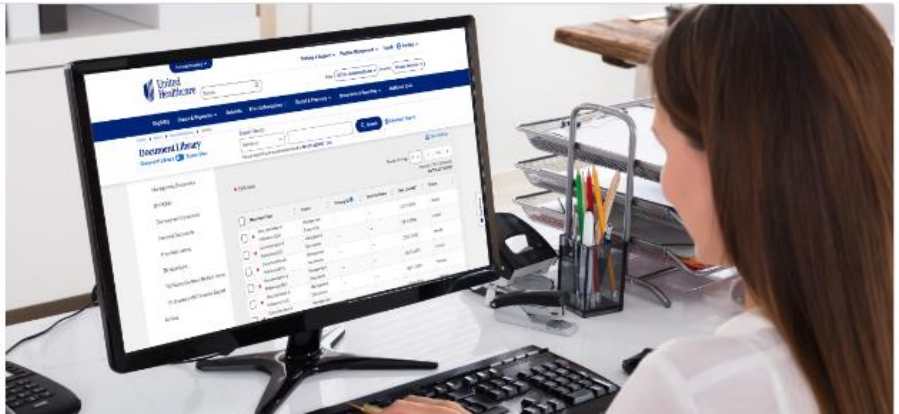
Welcome health care professionals

We invite you to use this website, created especially for health care professionals, to find resources that can help you as you care for your patients. Here you can find our medical policies, stay up to date on the latest news or get training on our many tools and benefit plans. This website is **there for what matters** to health care professionals like you.

Looking for a claim letter?

Forget the mail. Soon Medicare Advantage and commercial plan claim letters must be accessed in Document Library or through an API connection.

See the details



Health plans, policies, protocols and guides
Policies for most plan types, plus protocols, guidelines and credentialing information

Administrative guides and manuals
Specifically for Commercial and Medicare Advantage (MA) products

COVID-19 updates and resources

Drug lists and pharmacy
Pharmacy resources, tools, and references

Health plans
View health plans available by state

Choose a Location:

Education and training
Updates and getting started with our range of tools and programs

Reports and quality programs
Reports and programs for operational efficiency and member support

Telehealth
Resources and support to prepare for and deliver care by telehealth

News
Important news updates for you

Resource library
Tools, references and guides for supporting your practice

The UnitedHealthcare Provider Portal resources
Log in for our suite of tools to assist you in caring for your patients

Feedback

We invite you to use this website, created especially for health care professionals, to find resources that can help you as you care for your patients. Here you can find our medical policies, stay up to date on the latest news or get training on our many tools and benefit plans. This website is **there for what matters** to health care professionals like you.

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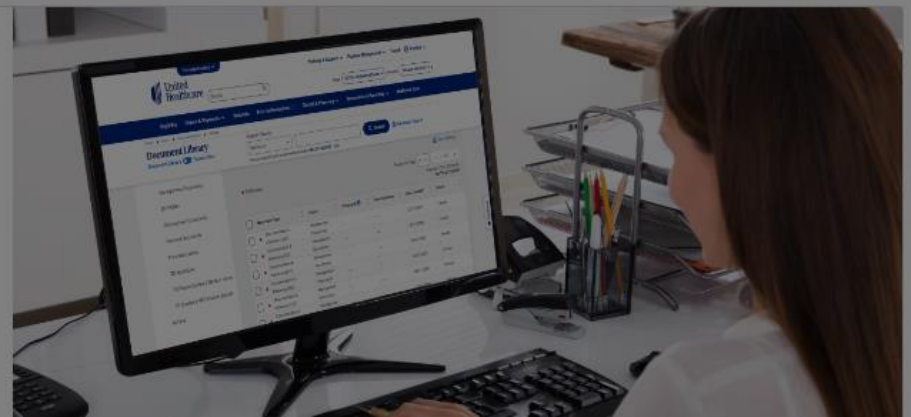


Healthcare Professional Education and Training

We provide a full range of training resources including interactive self-paced courses and instructor-led session. The training content is organized by categories to make it easier to find what you need.

- Digital Solutions
- Plans and Products
- Clinical Tools
- Coding Corner
- Smart Edits
- State Specific Training
- Instructor-Led Learning Events
- Delegated Providers
- Veterans Affairs Community Care Network (VA CCN)

Getting Started with UnitedHealthcare

This is the first course all new care providers should complete. Whether you are new to our network, have a new employee, or simply need a refresher, this self-paced course is designed to give you what you need to get started working with us.

Register for live training

Start course

Healthcare Professional Education and Training
- Clinical Tools
- Coding Corner
- Delegate Providers
- Digital Solutions Training and Guides
- Instructor-Led Learning Events
- Plans and Products
- Smart Edits
- State Specific Training
- Veterans Affairs Community Care Network (VA CCN)

Digital Solutions Training and Guides

Learn how you can save time, get better documentation and reduce paper by using our online self-service tools.

Find what you need fast

When reviewing an interactive self-paced guide, simply click MENU to see all content included. Then, select the topic you need for quick reference. Use the forward arrow to advance to the next page in order or use the HOME icon to switch topics at any time.

Portal Tools

Collapse All

Access and Registration

Access and New User Registration
Easily complete your registration and start using UnitedHealthcare's self-service tools. Our Registration and Access Management guide will walk you through the process step-by-step.

How to Create and Manage Users
Administrators will see how to create and manage users for the UnitedHealthcare Provider Portal

3rd Party Access Guide for Primary Access Administrators

Claims Overview

Overview of the features on the UnitedHealthcare Provider Portal for the entire claim process, from the initial submission of a single claim (1500) to checking status and submitting a reconsideration or appeal, if needed and more!

Register for live event

Document Library, Paperless Delivery and TrackIt

See how to get letters the day they are generated, access reports, track reconsiderations and pended claims, flag claims for easy access and more.

Register for live event

Getting Started with UnitedHealthcare and the Provider Portal

This is the first course all new care providers should complete. Whether you are new to our network, have a new employee, or simply need a refresher, this live event is designed to give you what you need to get started working with us: how to register, verify eligibility and get a member ID card, check prior authorization status, and more.

Register for live event

Prior Authorization and Notification

Learn how to check requirements, submit new authorizations / notifications, check status, and submit updates

Register for live event

Point of Care Assist

Adding real-time information to improve patient experience and outcomes

How It Works

Real-time members' health data is added to existing Electronic Medical Records for UnitedHealthcare members

Information is delivered as part of providers' current workflow process to ease administration and reduce re-work

Alerts providers to patient care needs, aligned to member-specific benefits

Information is updated in real-time and available 24/7

Prior Authorization By The Numbers:

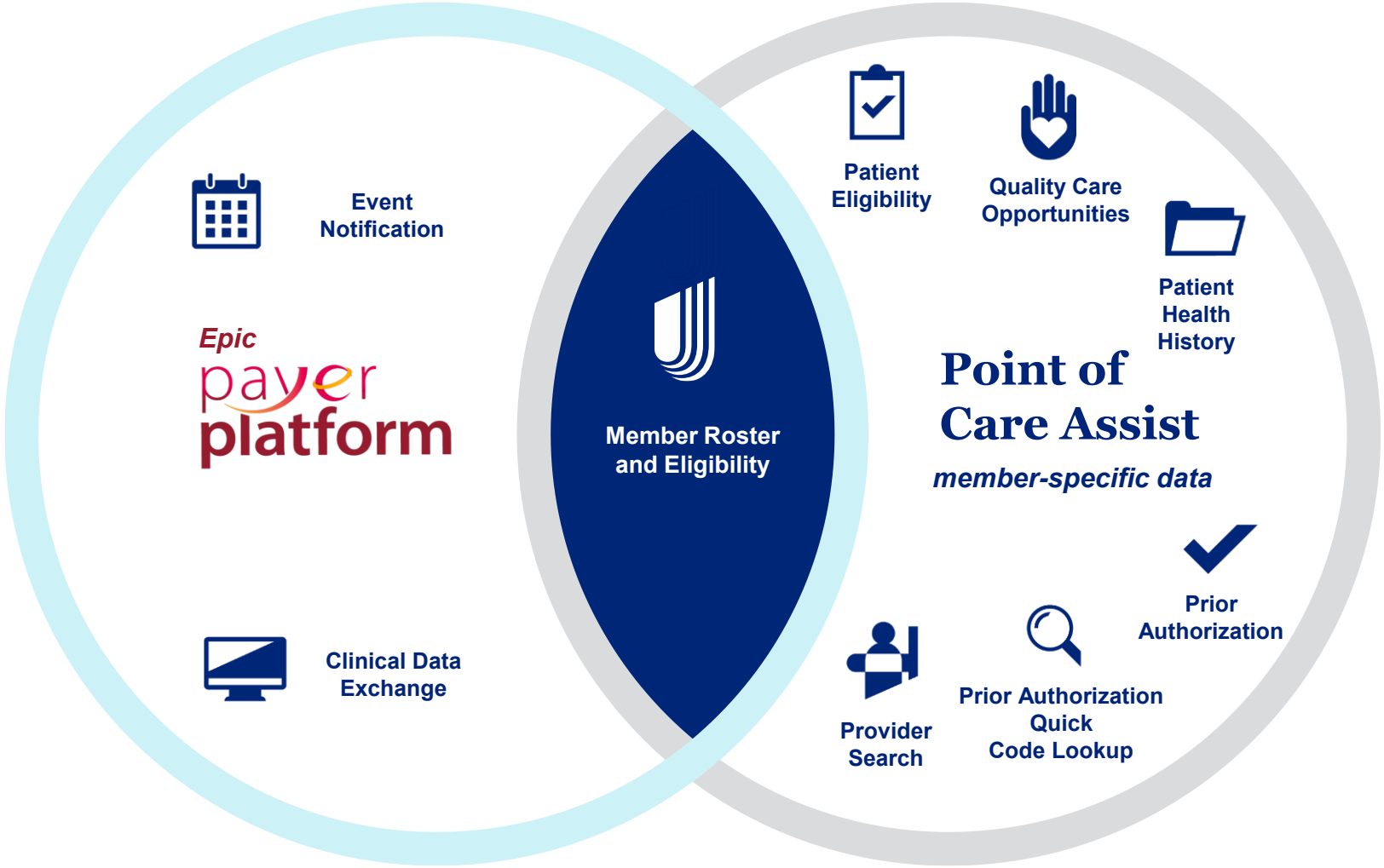
10,000
Authorization Requests

11 minutes
Time Saved per Request

Savings up to $65,000 and 1,833 staff hours

Submission Methods	Total Potential Savings with Point of Care Assist = $65,000 Provider Cost	Time Savings
Fully Manual	$7.52	16 mins
Partially Electronic	$6.50	11 mins
Fully Electronic	N/A	N/A

Digital Tools Comparison Example



Point of Care Assist resources

Check out more resources:

- **Point of Care Assist Self-Paced Course**
- **Point of Care Assist FAQs**

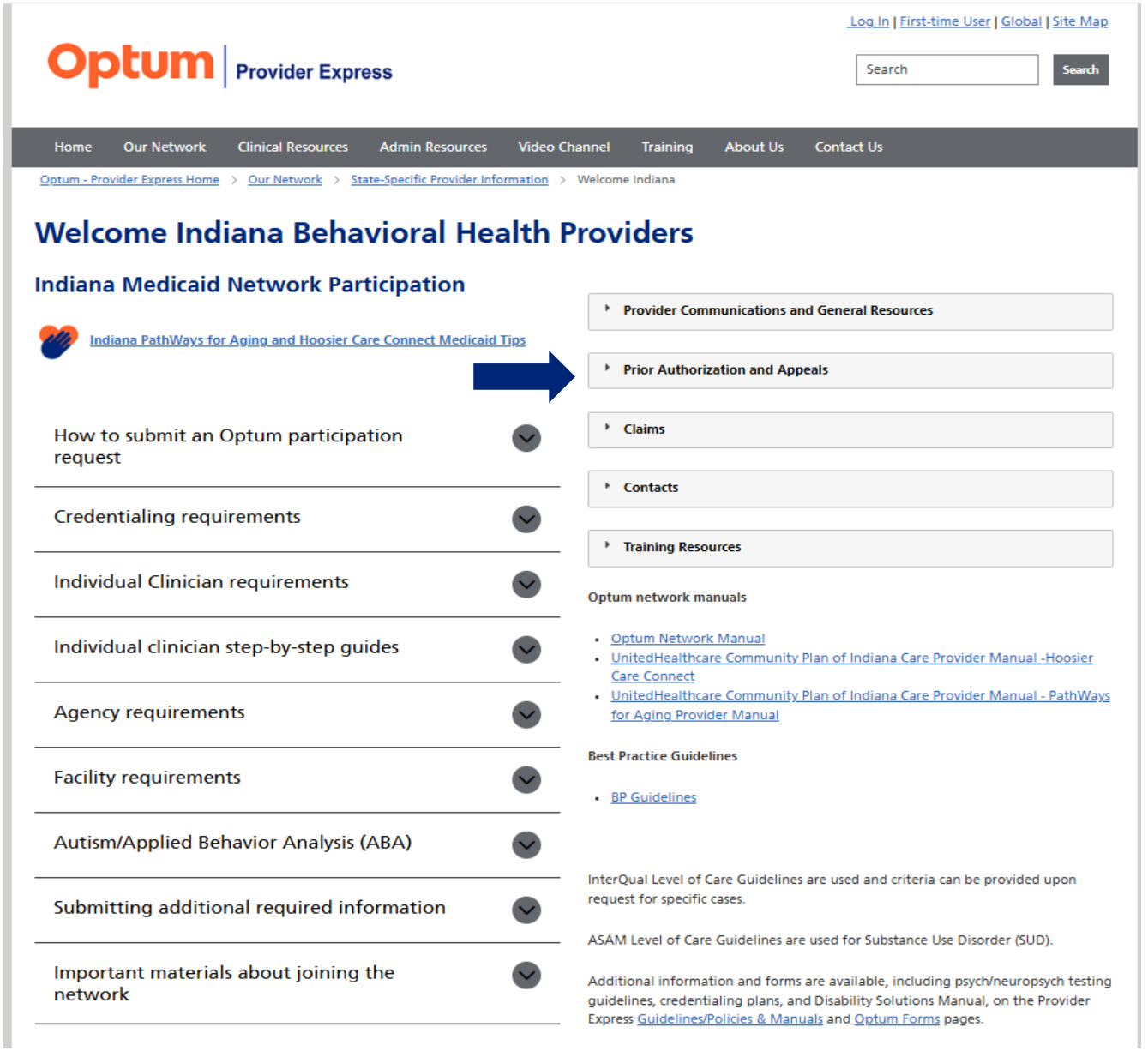
Contact Us

If you have any questions or want to learn more about Point of Care Assist, please e-mail us at **POCAnationalteam@uhc.com**.

Behavioral Health

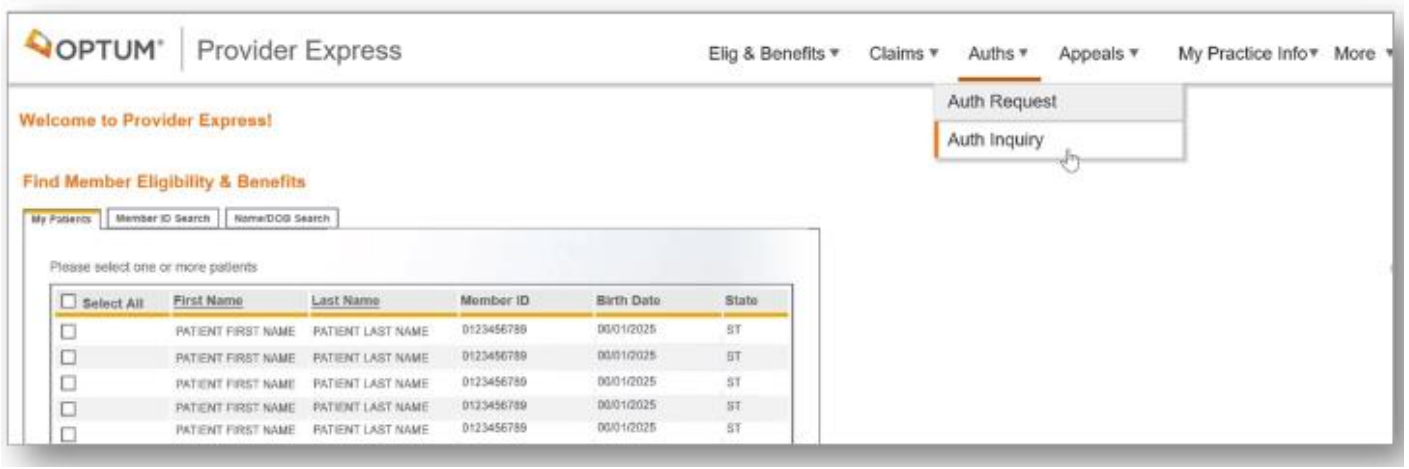
Behavioral Health: Determine Prior Authorization Requirements

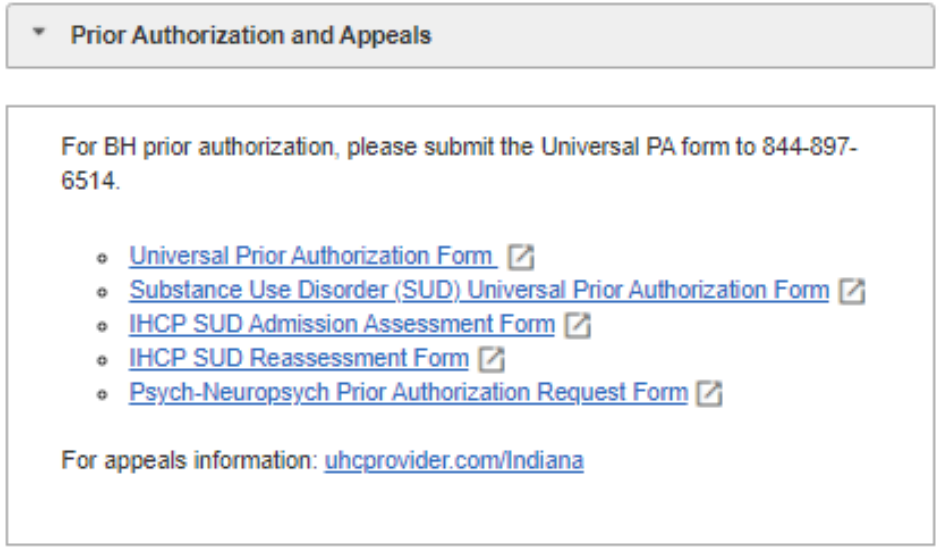
- Most outpatient behavioral health services do NOT require a prior authorization
- Call the number on the back of the member's card to determine if a prior authorization is required
- Or check online at: [Provider Express - Indiana Medicaid]



Behavioral Health: Request Prior Authorization

- Securely log-in to Provider Express and select “Auth Request” from the “Auths” dropdown box
- Use the paper Universal Prior Authorization Form from Indiana Health Coverage Programs Prior Authorization Request Form and click “Prior Authorizations and Appeals”
- Fax to 844-897-6514

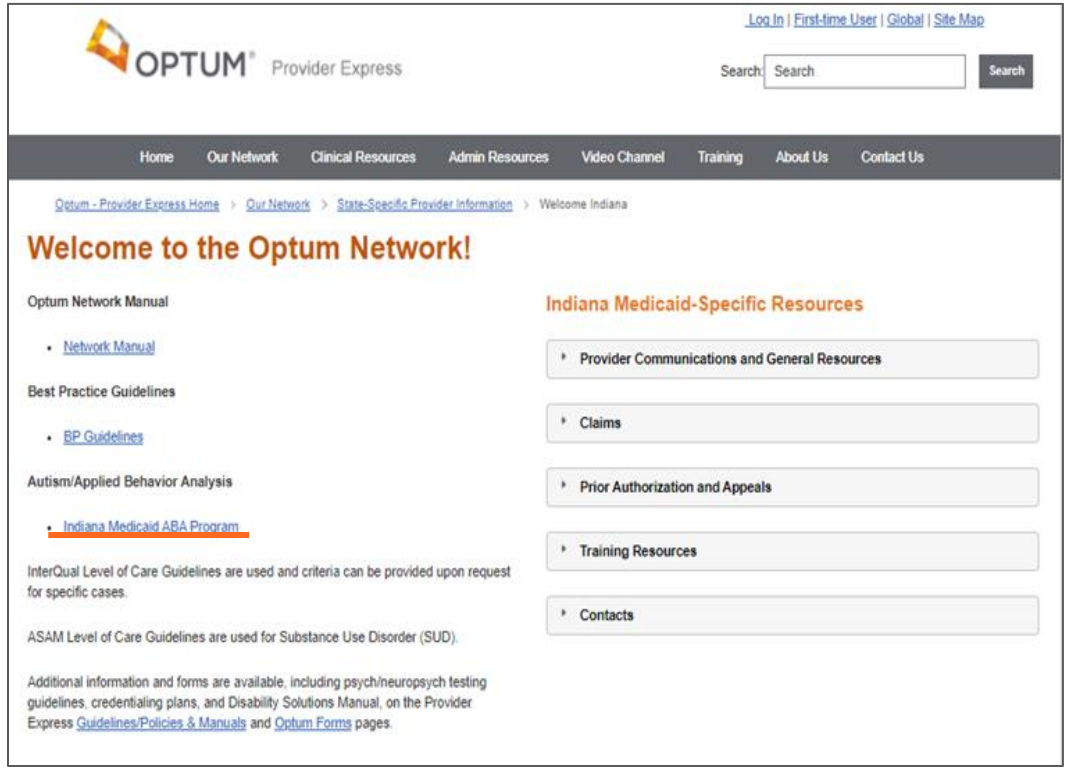




Behavioral Health: Request Prior Authorization for Applied Behavior Analysis (ABA) Therapy Services

Provider Express – Indiana Medicaid

Step 1

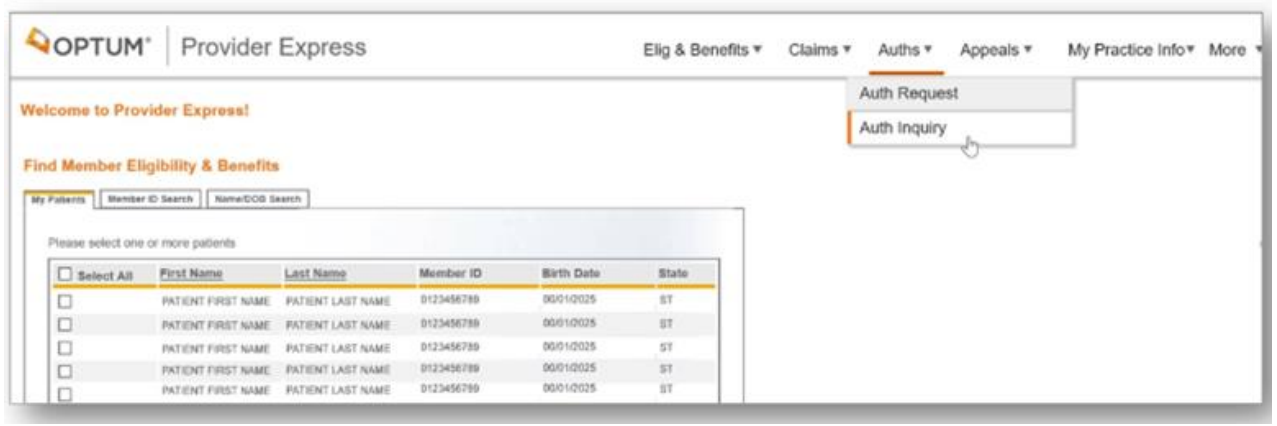


Step 2

Behavioral Health: Escalate to a Provider Advocate

If provider submits a prior authorization request and does not receive a response within the required turnaround time, do the following:

1. Check the Provider Express portal



2. Call the number on the back of the member's ID card
3. If 1 and 2 do not provide a response, please reach out to your Optum Behavioral Health Advocate

Behavioral Health: Appeal an Authorization Decision

In the event a prior authorization is denied, and an appeal is necessary, make sure to include the following information with the appeal:

- Member name
- Member date of birth
- Member Medicaid ID number
- Denial letter
- Any additional supporting documentation

Send to:

National Appeals Team

Attn: Appeals Department/Retrospective Review

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: 855-312-1470

Phone number: 866-556-8166 (8 a.m. to 8 p.m. Eastern, Monday through Friday)

Dental

Dental: Dental Services Requiring Prior Authorization

United Healthcare | Dental Benefit Providers

Prior authorization is required for, but not limited to, the following procedures:

- Endodontics (root canals, root treatments)
- Periodontics (gum tissue treatment)
- Prosthodontics (dentures)
- Oral surgery (bony-impacted extractions, frenectomy)
- Orthodontics (braces)
- Moderate/deep sedation anesthesia

Dental: Determine Dental Service Prior Authorization Requirements

- For a complete listing of procedures requiring prior authorization, refer to the Dental Provider Manual - UnitedHealthcare Community Plan of Indiana Hoosier Care Connect at uhcdental.com

- When requesting prior authorization, the practitioner must submit planned procedures for approval with clinical documentation supporting necessity before initiating treatment

- For questions concerning prior authorization, dental claim procedures, or to request clinical criteria, please call **Provider Services** at **844-402-9118**
  Hours: 8 a.m. to 8 p.m. ET Monday-Friday

Dental: Request Prior Authorization

- Dental providers can submit prior authorization requests online at SKYGEN DENTAL HUB. An account is required. Dental providers can also submit prior authorization requests via mail to the following address:

  UnitedHealthcare Dental

  Attn: Prior Authorization

  P.O. Box 1313

  Milwaukee, WI 53201

- The American Dental Association (ADA) Claim Form serves as the prior authorization request. To ensure proper processing be sure to check the box labeled "Request for Predetermination/Preauthorization".

Dental: Prior Authorization Timelines

The following authorization timelines will apply to requests for prior authorization:

UHC will make a determination and provide written notification on *expedited authorizations* within 48 hours of receipt of the request.

UHC will make a determination and provide written notification on *standard authorizations* within 5 calendar days of receipt of the request.

Authorization approvals will expire 180 calendar days from the date of determination.

Vision

Vision: Prior Authorization

- March Vision Care does not require prior authorization for most routine vision services
- For routine exams, frames, and lenses, please check member eligibility and obtain a benefit confirmation on the eyeSynergy.com provider portal. An account is required
- For medically necessary contact lenses and fittings, providers need to submit a pricing request form: Medically-Necessary-Form-Editable.pdf (marchvisioncare.com)

Vision: Request a March Vision Care Prior Authorization

- Obtain confirmation by logging in to eyeSynergy.com and searching for the member, verify eligibility and benefits, and generate a confirmation number
- Confirmation number is an 11-digit identification number generated when benefits and eligibility are verified
- Benefits that generally require confirmation numbers include, but are not limited to:
  - Replacement frames and lenses
  - Medically necessary contact lenses for Medicaid members
  - 2 pairs of glasses in lieu of bifocals
  - Prescription sunglasses

Vision: Request a March Vision Care Prior Authorization (cont.)

For medically necessary contact lenses, providers need to submit a pricing request form prior to submitting the claim for reimbursement. Email the completed form with the patient's current eye exam/doctor's notes to providers@marchvisioncare.com.

Medically-Necessary-Form-Editable.pdf (marchvisioncare.com)

Prior Authorization Appeal Process: All Service Lines

- All providers may appeal a prior authorization adverse determination
- An appeal can be filed within 60 calendar days from the date of the adverse determination
- Submitted appeals will be acknowledged within 3 business days
- Please submit your request by mail to:
  - UnitedHealthcare | March Vision Care Attn: Medicaid Vision Appeals P.O. Box 30988 Salt Lake City, UT 84130

Prior Authorization Appeal Process: Outcome

- A decision on the appeal is made within 30 calendar days unless it is expedited
- Expedited appeals are resolved within 48 hours of receiving the appeal and every attempt is made to notify the member orally as well as in writing
- A notification of standard appeal decision is sent within 5 business days of the resolution
- In rare cases, a 14 calendar-day extension may be required. If this is required, both the member and provider are notified
- Appeal notification letters indicate how to file an appeal based on the type of service

Options if the Authorization is Denied

Utilization management (UM) appeals process

1. Peer-to-peer within 7 (HCC) or 15 (PathWays) calendar days

Call 800-955-7615 8am-8pm ET

2. Next level appeal

3. Fair hearing

Type of request	Decision Turnaround Times	Practitioner notification of approval	Written practitioner/member notification of denial
Non-urgent pre-service	Within 5 business days or 7 calendar days (whichever comes first) of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/expedited pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request
Concurrent review	Within 48 hours	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination; at least 10 business days before the date of action

Medical Network Provider Advocate Team

Provider Account Managers:

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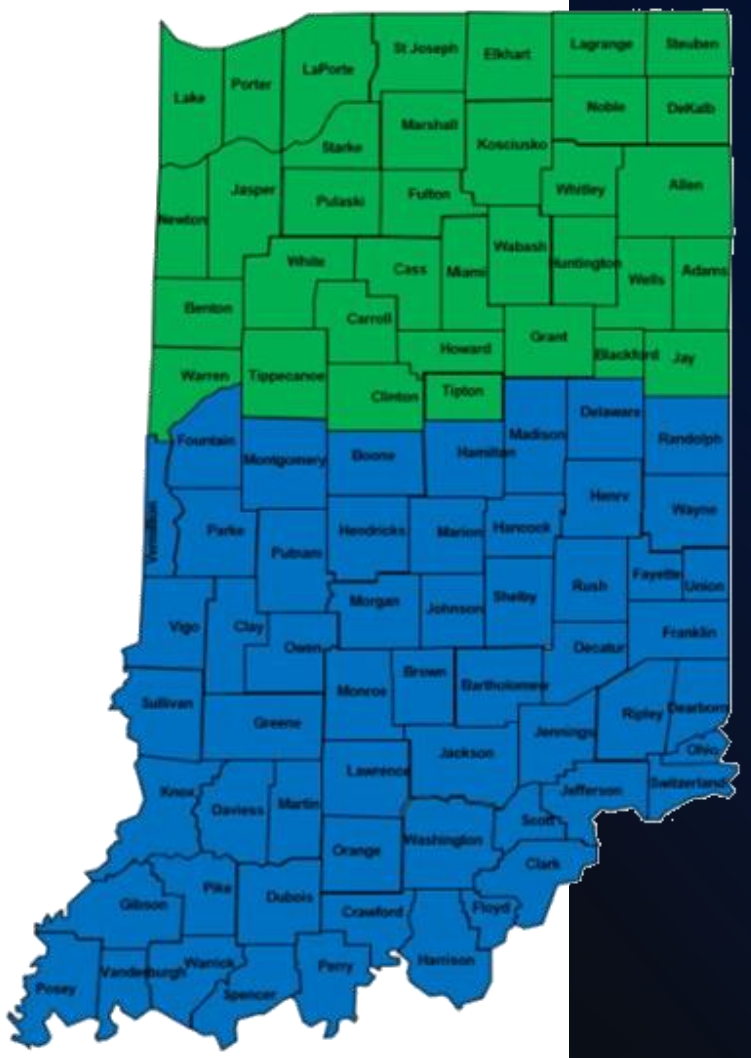

Your Dental Advocate Team

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Your March Vision Advocate

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Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): uhcprovider.com/INcommunityplan
- UHC Dental: uhcdentalproviders.com
- March Vision Care: marchvisioncare.com
- Optum Behavioral Health: Provider Express – Indiana Medicaid

Thank you

Questions?

United Healthcare